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A Project To Develop a Marketing Plan for Dwight David Eisenhower Health Service Region By Audit

A Graduate Management Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

by

Captain James R. Alarcon, MS

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TABLE OF CONTENTS

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ABSTRACT

This Graduate Management Project will be instrumental in developing marketing plans for Dwight D. Eisenhower Army Medical Center (DDEAMC) which are responsive to the information needs of its publics (providers/ patients). The methodology was focused on the Health Service Regionalization activity (selected services) at DDEAMC and followed a marketing audit format: Marketing environment audit, marketing strategy audit, marketing organization audit, marketing systems audit, marketing productivity audit, and a marketing function audit. Using the audit findings, the marketing audit process was concluded with a recommended marketing plan for a HSR service provided. Findings were obtained by observation, from secondary data sources, by survey of key staff at the supported health care facilities, and by informal interviews with personnel responsible for accomplishing the Health Service Regionalization objectives for DDEAMC. Findings consisted of problems associated with marketing knowledge, marketing relationships, and marketing systems.

INTRODUCTION

Dwight D. Eisenhower Army Medical Center and other health care facilities, both military and civilian, are currently facing a period when resources are becoming scarcer, and strategic planning efforts are increasing. When resources (funding, manpower, etc.) become scarce, then strategic planning, a proactive tool for the future, becomes important in ensuring that resources are efficiently managed.

Marketing (research, planning, and auditing), a major component in strategic planning, recognizes the need to assess both the internal and external organizational environments to capitalize on resource efficient options. Additionally, marketing identifies those publics which resource scarcity may affect and allows the organization to be proactive in prompting awareness or educating those publics.

The Health Services Command 1990 Strategic Plan, under the organizational goal of "Sustainment," provides the following guidance: " To develop and implement education strategies to keep all constituencies informed about health service as provided." This sustainment objective can be interpreted as mandating subordinate units to establish marketing programs or equivalents.

STATEMENT OF THE PROBLEM

Dwight D. Eisenhower Army Medical Center (DDEAMC) does not have structured marketing plans for communicating information with its publics.

LITERATURE REVIEW

Marketing literature covers a myriad of subject matter relating to services and products. Therefore, to narrow the marketing agenda for this project, the student will analyze the importance of information in health care services, discuss the definitions of marketing, address the strategic placement of marketing, and examine the major processes involved in marketing. The literature review will be concluded with a summary detailing the best approach to follow in developing a marketing plan for DDEAMC.

Information

Information's ability to motivate both negative and positive behavior in publics can be considered a critical factor in health care service delivery (Kotler, & Clarke, 1987). The criticality of information passage to involved publics can be explained by drawing a contrast between the marketing of packaged goods and the marketing of health care

services. Packaged goods marketers usually work with low involvement, low risk, and low priced tangibles that are easily sampled and provide immediate reinforcement or reward. Hospitals, in contrast often work with high involvement, high risk, and high priced intangibles that cannot be sampled in advance and do not provide immediate reinforcement or reward. As a consequence, publics perceive greater risks in the purchasing of services than of products and seek more pre-purchase information of services than products (Mindak, 1986).

In order to monitor the influential appropriateness of communicated information, military hospital managers should be aware of the informational content it delivers to its publics (providers/ beneficiaries).

Efforts by military hospital management to manage information appropriately can be exemplified by the increase in strategic planning, the initiation of " Total Quality Management," and the institution of the Composite Health Care System. All of the latter three applications are destined to improve information monitoring and provide methods to shape the destiny of the military health care institution.

Since information influences public behaviors, methods need to be designed which can appropriately

monitor behavioral effects. An effective method to use in the evaluation and monitoring of communicated information is the institution of a marketing plan within the organization (Kotler & Clarke, 1987).

MARKETING

Within the corporate culture of military hospitals, marketing is not considered a common practice. For example, military hospital manpower and equipment authorization documents do not identify services nor divisions that are exclusive for marketing practices. This lack of a particular marketing niche in the military hospital organization could prompt a mismatch of resources to planned objectives. Therefore, the hospital manager should be familiar with the definition, placement, & processes (research, planning, audit) of marketing to allow creativity, innovation, and resource-consciouness for market planning endeavors.

Marketing: Definition

Because an identified beneficiary population exists for the military hospital, there may be doubts from management that "Marketing" is necessary. This negative perception of marketing is the failure of military hospital management to view marketing as more

than just an advertising or public affairs stunt. Therefore, by defining the term marketing, military hospital managers may take the first step in determining what role marketing can play for them.

Although marketing definitions vary, the benefits of marketing require its incorporation into hospital operations. For instance, Zikmund (1989) addresses marketing as an element which helps an organization meet the needs of its publics, supports the focus on long-term returns rather than immediate volume, and permits integration into other organizational functions. Another author, Bond (1989) views marketing as a custom-built process oriented to meet the needs of the organization and user publics, and judged by established criteria. The student's analysis of what the latter two authors are describing, is that an organization must be alert to the needs of internal and external publics, be proactive by establishing longterm strategies, integrate marketing applications throughout management, and create measurable objectives to determine the effects of marketing.

What could these definitions of marketing possibly offer to a nonprofit military hospital manager who has a defined user public (providers & beneficiaries)? The military hospital is not a for-profit nor the usual nonprofit organization.

Resources (U.S. tax dollars) are provided on retrospective productivity or a workload basis (Medical Care Composite Units). Therefore efficient use of those limited funds must be exercised. Health care programs initiated by military hospital management must be sensitive to resource constraints (dollars, supplies, manpower, equipment, facility space, etc.) to be efficient. Thus, prudent military hospital managers should consider the use of marketing to evaluate their particular public's needs and to establish resourced strategic objectives.

The role for marketing in the military health care organization can be analyzed through the four elements of marketing (market mix) as discussed by Kotler and Clarke (1987), & Rowland & Rowland (1984):

a) Product and services: The type and volume of service delivered. The profiles of patients or providers using services, their demand levels, or the benefits obtained by the provider or patient. b) Place: The framework of the delivery design established. The access characteristics defined by the hours of availability, the locales offered, or the referring mechanism for the services.

c) Price: The price or the cost of the service to the public. Price may include the time waited for access,

or the verification processes required to be followed before access.

d) Promotion: The communication of service availability to the community and providers. The staus of media relations. Promotion becomes effective when management can identify their targetted public and therefore focus advertisement activities appropriately.

Kotler and Clarke (1987), and Rowland and Rowland (1984) have provided parallel analyses of the marketing mix (service, price, place, and promotion) and marketing process relationship. With knowledge of the marketing mix, military hospital management can use these four elements as key reference points to provide a quick marketing overview of the services they offer to their publics.

Marketing: Placement

When military hospital management is planning for health care with limited resources, it would be sensible to establish marketing goals within the organization's strategic plan to ensure compliance. The literature, likewise, supports the pairing of marketing and strategic planning. For example Zikmund (1989) and Barry (1986) both view strategic planning with marketing as processes that are futuristic,

integrative, resource conscious, unlocking uncertainty, and sensitive to the changes in a public's needs. In analyzing these relational aspects, the placement of a military hospital's marketing goals and objectives would be appropriate within the strategic plan.

Marketing: The Process

If military hospital manager is aware of the importance of service related information, the definition of marketing, the placement of marketing within an active strategic planning process, then the marketing process may begin. This process includes research, planning, & auditing.

The next three subtopic headings under this literature review will provide examples and analyses derived from selected marketing scholars who have provided guidance in marketing research (Part I.), planning (Part II.) and auditing processes (Part III.). With the marketing processes to follow, a research methodology for marketing a military hospital service was developed.

I. ***MARKET RESEARCH FORMAT:***

In a military hospital, the information and data produced directly or indirectly from operations can have significant impact on a process in marketing called market research. For instance Bond (1989), and Lovelock & Weinberg (1984), both recommend the market research process for analyses of information generated from operations and for use in organizational decision-making. It is obvious that an organization should be very observant of all data involved in its operations and make decisions based on the functional relationships identified. By analyzing the functional relationships observed in data, the market research process can help military hospital management identify the needs and demands of their publics.

Several marketing scholars have imparted their interpretation of market research. For instance, it is apparent to the student that Kotler and Clarke (1987) view market research as an applied research technique which is systematic in the gathering and the analysis of data. In this respect, market research allows the organization to determine the situational needs of their public and to decide the appropriate matching goals. The following quote from Kotler and Clarke reveal market research as an applied research technique:

> Marketing research is the systematic design, collection, analysis, and reporting of data and findings relevant to a specific marketing situation or problem facing an organization. (Kotler and Clarke, 1987, p. 168)

Likewise, Zikmund (1989) has the same view as Kotler and Clarke, in that market research is an applied research technique that helps to develop organizational strategies. The similar views of market research between Zikmund (1989), and Kotler and Clarke (1987), can be obtained from the following quote:

> Marketing research can help implement the marketing concept by obtaining information that identifies consumer's problems and needs, by improving efficiency, and by evaluating the effectiveness of marketing strategies and tactics. (Zikmund, 1989, p. 23)

In short, the authors present an appropriate description of "what" and "how" market research can do for the military hospital manager.

Still lacking in this section of the literature review is a description of the methodology to follow if a military hospital manager is planning to perform

marketing research. Kotler & Clarke (1987) address their methodology as a five step process that contains the identification of objectives, the selection of research instruments, the creation of a data collection design, and the development of an analysis/presentation (see Appendix A). This is a very brief and concise approach unlike Lovelock and Weinberg's (1984) methodology that provides more specificity within a 10-step framework design. (see Appendix B). The decision, of which methodology to choose, becomes a decision based on the situation or management's perspective. For example, the "time" available may be a constraint for hospital management and therefore Kotler and Clarke's research format may be more pertinent. If hospital management is inexperienced in market research fundamentals then the specificity of Lovelock and Weinberg's research format may be more applicable. Basically, the research methodologies can be customized by selecting those paragraphs from each format more applicable to meet the needs of the military hospital or the research required.

For the military hospital there are a variety of approaches/strategies involved in the design of the methodology, and depending on the types of problems and data analyzed some approaches are better than

others. For instance, Yin (1989) proposes a case study approach when the research problem is answering a "how" or "why" question. Yin also associates the case study approach with research involving a lack of controls over behavior and focusing on contemporary events (see Appendix C). This list of different research strategy approaches in appendix C should provide to military marketers some guidance in conducting their research. Finally, once a design for the methodology, and a research strategy are selected for the target population there are various sampling instruments to use which range from observational methods, surveys, to experimental methods.

Service targets for market research in the military hospital can be best identified by reviewing the marketing mix. Provisions by Garda (1988) infer that reviewing and analyzing the relationships of variables which exist in the product/service, price, place, and promotion (market mix) of a service activity in health care
can suggest where research may be directed (see Appendix D). The market mix provides a prudent approach to initiating market research if one of the four components appears to be out of place or ineffective for the military hospital.

Is market research necessary? Zikmund (1989) establishes a fairly sound criteria grouping that can help a military hospital recognize whether marketing research is required. He provides a four-step criteria review based on time constraints (for the decision), availability of data, nature of the decision (strategic/tactical), and benefits versus costs (see Appendix E). What makes the utility of this criteria so appealing is that if any of the four criteria are not met then market research is not necessary nor conducive to organizational advancement. Examples of this utility could be the minimization of manhours spent on unneeded market research, or the improvement of management practice guidelines for market plan developement.

II. *MARKETING PLAN:*

The decision-prompting feature of the marketing research process makes establishing goals and objectives, based on findings, probably the most important link to the marketing plan. For instance, planning is normally a future-oriented activity that expects to accomplish some goal or objective by providing the "how to do" portion. While marketing (research), attempts to reveal the "what" that needs to be performed within an organization. Together,

planning and marketing become the market planning process, which now represents a strategically focused action protocol to meet organizational marketing objectives based on decisions. Therefore, market research should precede market planning.

Several marketing scholars have described market planning. For instance, Bond (1989), and Kotler and Clarke (1987), together, have parallel perceptions about market planning within the organization. Their parallel perception can be best explained by their references to analyzing strengths and weaknesses, and providing direction in the form of objectives. In combination, Bond, and Kotler and Clarke, do more for the military hospital by emphasizing the proactive analysis of the organization's environments (external & internal), competition, information systems, public's needs, and by establishing pertinent objectives. Their perspectives could enhance the effectiveness of the military hospital strategic planning process which requires a proactive analysis of data and information obtained before objectives are synthesized.

Formats for a marketing plan structure or outline can be found in marketing publications by Bond (1989),

Kotler and Clarke (1987), Lovelock and Weinberg (1984), and Rowland and Rowland (1984), examples of these formats are located in appendixes F through I.

A prudent military hospital manager should seek to review the various marketing plan formats available and select those components which will meet a hospital's planning needs best. To analyze every component would not benefit the researcher nor the readers of this project. It would be more beneficial to observe the general similarities amongst all four marketing plan sources (see Appendixes F, G, H, and I) and use those similarities as starting points for a military hospital marketing plan. Those components most utilized are the following: Situational analyses, marketing objectives with associated strategies, action plans or schedules, an overview of the budget impact, and a routine evaluation (audit) or control feature to monitor progress or failure.

III. ***MARKETING AUDIT:***

A marketing plan requires an evaluation or control mechanism to evaluate marketing activity performance. Marketing literature indicates that mechanism to be the market audit.

Various marketing scholars have described the essential elements of the marketing audit. The

marketing audit descriptions are found in literature as being either "general" or "specific." Bond (1989) provides a general description of the marketing audit which outlines management's role, as implied from the following quote:

> The necessary assessment of the market and preparation of the marketing plan . . . comprehensive, systematic, independent, and periodic . . . validates current efforts, identifies existing or potential problem areas, identifies overlooked opportunities, and recommends a plan of action to improve the hospital's overall marketing performance. (Bond, 1989, p. 79)

Unlike Bond, Kotler (1984), in the quote to follow, outlines more specificity in his description of the marketing audit by identifying distinct organizational components:

> The marketing audit consists of examining six major components of the company's marketing situation. The six components are . . . the Marketing-environment audit, the marketing-strategy audit, the marketing-organization audit,

> the marketing-systems audit, the marketing-productivity audit, & the marketing-function audit. (Kotler, 1984, p. 766)

From the quotes provided from Bond (1989) and Kotler (1984), a military hospital can ascertain that the marketing audit is a very comprehensive process that assesses and evaluates an organization's marketing performance. Additionally, it appears that the audit can be used to correct or identify deficiencies, to identify opportunities, and to prepare a marketing plan. In the opinion of the student, any organization, be it military or not, should as a common business practice have a feedback or a self-evaluative process to routinely determine if the goals of the organization are being met or not being met, and adjust to meet those goals.

The comprehensive nature of the audit under Kotler (1984), provided in more detail under appendix J, is endorsed by marketing scholars such as Bond (1989), Barry (1986), and Zikmund & D'Amico (1986). All four marketing scholars, including Kotler (1984), reference to Philip Kotler's selected component format (see Appendix J) in implementing a marketing audit. As a result of repeated endorsement by other marketing scholars of Philip Kotler's component audit format,

the student perceives that a validation of the audit components to be analyzed has been achieved. With a valid audit component listing available for the military hospital, there remains only an explanation of the process or steps to follow.

All four marketing scholars Bond, Barry, Zikmund & D'Amico, and Kotler endorse the following marketing audit steps:

a) Select an objective person to perform the audit.
b) Develop the scope of the audit through objective development.
c) Collect primary and secondary data.
d) Present a report to management.

Essentially this is a very logical and simple auditing process that should be functional within the military hospital organizational structure.

The comprehensive nature of the market audit presented by marketing scholars offers the military hospital the opportunity to, as MacStravic (1986), explained it, "to discover how to improve current marketing efforts, both service and communications" (p. 61). This opportunity also gives a military hospital the ability to have a greater strategic role by enabling change to be detected when organizational objectives fail to be met. It can therefore be deduced that the marketing audit should be a process routinely

and periodically utilized in the monitoring of military marketing operations.

SUMMARY

The substance of the review found information to be critical in service-type organizations and marketing to be the vehicle for a safe delivery of that information to respective publics. Marketing, as a result of that delivery, becomes a constructive partner of the strategic planning process. Likewise, knowledge of the components of the marketing mix and their associations in exchange relationships adds a strategic value. Therefore military hospital managers, within service-type organizations operating with limited resources should be knowlegeable of marketing processes to enable strategic insight.

Market research, market planning, and market auditing processes were reviewed. Market research provides the data collection and information from which market planning can determine the appropriate decisions (objectives developed). The marketing audit comprehensively evaluates the effectiveness of the marketing objectives, and serves as a means to readjust the organization to meet its objectives.

In the ideal marketing organization--market research, planning, & auditing would create a cycle of

marketing (see Appendix K) that would continuously design research, establish proactive flexible plans, and monitor the feedback provided by the audit to improve or change the organizational objectives (plans). This self-adjusting or cybernetic marketing system could serve as a foundation in establishing a marketing plan for a military hospital management by introducing the proper combination of marketing processes to current operations.

Current military hospital operations include numerous bits and pieces of the marketing mix (services, price, place & promotion), service components, and exchange relationships that are not recognized as part of a marketing plan nor program. It is within the perception of this student, that an appropriate comprehensive evaluation or audit of the unstructured marketing practices at the military hospital can serve as a base to initiate a marketing plan. The marketing plan could be a product of the comprehensive nature of the audit and the data collection by survey (see Appendix L).

Due to the comprehensiveness of the marketing audit, two coherent services within the DDEAMC Health Service Regional (HSR) activity have been selected as

the targets of this project. The selection of specific targets meets the requirement for establishing effective marketing plans (Bond 1989).

PURPOSE

The purpose of this project was to develop audit derived marketing plans for the Health Service Region at Dwight D. Eisenhower Army Medical Center (DDEAMC).

OBJECTIVES

The objectives of this applied research project are to:

1. Perform a marketing audit (service components) of the HSR in accordance with appendix M. This includes interviews with DDEAMC staff and secondary data searches.

2. Perform a survey of the eight medical department activities (MEDDACs) and two health clinics. (see Appendix L).

3. Develop marketing plans for the DDEAMC HSR based on findings obtained from the audit and survey.

The three objectives will be met through the application of the methodology to follow. The success of this project will rest on how well the objectives can be met and how well the student can measure current marketing efforts at DDEAMC.

METHODS AND PROCEDURES

The objectives of the project were carried out in a nine stage methodology (see Appendix K) adopted from the marketing audit service components of Bond (1989), Barry (1986), Zikmund and D'Amico (1986), and Kotler (1984). The initial procedures surrounding the selection of an auditor and the scope of the marketing audit were determined to be the student and the Health Service Region (two services) respectively.

Initially, a marketing audit of DDEAMC's service components was performed. A presurvey was performed on the questionnaire (Appendix L). After making adjustments to the survey, the survey was mailed to the Deputy Commanders for Clinical Services (DCCS) or their equivalents at the health clinics (for more detail see "validity & reliability" section). The DCCSs were given 30 days to return the surveys. Once the marketing audit of the service components (DDEAMC) and surveys were returned, recommended marketing plans based on findings were developed.

FOCUS OF THE PROJECT

The focus of this marketing project was the DDEAMC Health Service Region (HSR). The selection of the HSR was determined between discussion with the student and the Deputy Commander for Administration at DDEAMC to keep the project time-manageable. Two unique service functions of the HSR where selected in order to meet the objectives of this project.

The HSR is managed at DDEAMC under the office called the "Regional Integration Office." The office of Regional Integration is headed by the Deputy Commander for Regional Integration (DCRI) and supported by an Assistant DCRI, who is the Chief of the Department of Primary Care & Community Medicine (DPCCM), a secretary (DCRI Office), and a Civilian health care administrator (DPPCM). The HSR consists of eight MEDDACs & two health clinics (listed later). The two unique service functions identified to undergo the audit within the Health Service Region are:

One, service function, involves the office of the DCRI where consultant visits from DDEAMC are scheduled, and coordinated to occur amongst the eight MEDDACs and the two external ambulatory U.S. Army health care clinics. The consultants can be clinical or administrative members who may provide patient

care, training, consultation, or administrative support to the MEDDACs.

The other service function is a patient facilitation process for tertiary care coordinated by the Assistant DCRI and the health care administrator supporting DPCCM. This facilitative process is used by the region when normal access to the MEDCEN for tertiary patient care is not possible due to workload or when special case patients require immediate care. "MILDRED" is the name of this facilitative process and is not an acronym. The concept of "MILDRED" is a term adopted by DDEAMC as result of the Chief of DPPCM's regional work at another military health care facility. Upon C, DPPCM's designation as the assistant DCRI at DDEAMC, "MILDRED," (a term that actually represents a person's name who regulated patient care solely at one of Mayo's health care clinics from admission to discharge planning), became a marketing promotion symbol for special case patient facilitation.

MILDRED provides MEDDAC's referring providers / patients within the Health Service Region (HSR) an organized office to coordinate tertiary care referrals when access appears severely limited at the MEDCEN or

when special case patients require immediate care. Special cases can be of command interest or a matter of life and limb.

The Health Service Region of DDEAMC includes the following MEDDACS:

1) Fort Jackson
2) Fort Benning
3) Fort Stewart
4) Fort Rucker
5) US Army Health Clinic, Fort McPherson
6) US Army Health Clinic, Fort Buchanan
7) Fort McClellan
8) Redstone Arsenal
9) Fort Campbell
10) Panama, Canal Zone

Not included in this study were the HSR's other tri-service elements and other Armed Service Medical Regulating operations (ASMRO).

ETHICAL MEASURES

Participants were voluntary. Any participants who were to be questioned, or were providers of relevant information for this project, were fully informed of the purpose and nature of this project. In all situations concerning this project, ethical practices were exercised, and requests for anonymity were honored.

VALIDITY & RELIABILITY

This project involved a case-study qualitative research design using a survey questionnaire (see Appendix L) for the HSR MEDDACs and health clinics, and a service component audit (see Appendix M) targetted at DDEAMC HSR operations. These two measuring instruments were be used to complete the stages of the methodology (to follow).

A presurvey was initiated with DDEAMC's internal staff (DCCS, DCA, DCRI, asst. DCRI, and a Department Chief) to ensure the survey questions were a valid instrument (face validity) in obtaining information from the MEDDAC Deputy Commanders of Clinical Services, and chief clinicians at the two health clinics. The validity (face validity) of the service component audit questions (see Appendix M) directed to DDEAMC HSR marketing operations were verified by the DCA, and DCRI at DDEAMC. Additionally, these audit questions have been recommended by marketing scholars as noted on appendix M.

Yin (1989) ascribes to improving reliability in case studies by provision of protocols. In our case, the MEDDAC survey and the list of audit questions were ensured reliability by pretesting the survey and creating a protocol.

Campbell & Cook (1979), would suggest that the internal threats to validity are history, maturation, testing, instruments, selection, or diffusion. The key is to determine if threats have affected this project's data and therefore reduced the validity of the findings.

The external validity, per Zikmund (1989), were defined for this project in terms of the student's ability to make marketing generalizations for the DDEAMC Service Region.

SAMPLING

The sample size for the survey (see Appendix L) will be n=10; Each DCCS (total 8, each MEDDAC) and health clinic chiefs (total 2, two external clinics). The total population of providers who use the HSR referral process varies at each MEDDAC due to the recent deployment of assigned physicians and the backfills of reserve (Desert Shield) providers. The questions (see Appendix M) targetted at DDEAMC HSR operations were not part of a sampling process, and were directed at the entire population that is involved in the operation of the HSR at the command level. The audit questions (targetted at DDEAMC HSR operations, see Appendix M) were directed to the following personnel:

DCA, DCCS, DCRI, assistant DCRI, chief of ambulance services, public affairs officer (PAO), chief budget analyst, chief of regional mobilization, secretary to DCRI, health care administrator for department of primary care & community medicine, chief information management division, DDEAMC strategic planning officer, chief supervisor of the medical expense and performance reporting system (MEPRS), manpower analyst, and the chief of patient administration.

STAGES OF THE METHODOLOGY

Stage I: The developmental stage involved further review of the literature, personal contact with experienced marketing sources (military/civilian) to enhance the marketing methodology, and discussion with senior staff at DDEAMC to introduce the goal of the project and establish a scope (see Appendix K for flow chart).

Stage II: Initiated a presurvey to a sample group at DDEAMC. Collected data and recommendations from the sample group to refine the survey questionnaire (see

Appendix L) prior to forwarding to MEDDAC DCCSs, and equivalents at the two health clinics. Once the questionnaire was complete it was forwarded by mail.

Stage III: Performed a marketing-environment audit of the HSR, which consisted of focusing on the forces and trends in the marketing environment. Secondary data and personal interviews with structured questions (see Appendix M) was utilized.

Stage IV: Performed a marketing-strategy audit by reviewing the marketing objectives / marketing strategies of the DDEAMC 1990 Strategic plan for marketing the HSR activity, and appraised how well the marketing objectives were adapted to the current / forecasted marketing environment. The appraisal considered the clarity of objectives and if resources were a consideration in their development. Secondary data and personal interviews with structured questions (see Appendix M) were utilized.

Stage V: Performed a marketing-organization audit by personal interviews to obtain data from key points of contact identified as action offices for the execution of the HSR marketing objectives listed on the DDEAMC Strategic Plan. Interviews served to

evaluate the capability of the action offices at DDEAMC in implementing the necessary strategies for the forecasted environment. The personal interview consisted of questions derived from Kotler's (1984) service component list (see Appendix M).

Stage VI: Performed a marketing-systems audit on the HSR through the continuance of the interview process addressed under Stage V. The marketing systems audit was used to provide information regarding the existence and effectiveness of the various systems (marketing information systems, marketing planning systems, and marketing control systems) in the HSR marketing operation. Additionally, resource allocation for the HSR activity was reviewed to determine if they actually have the resources to execute the planning and controlling system responsibilities. Secondary data within the DCRI's office (minutes, reports, rosters) was reviewed in this stage.

Stage VII: Performed a marketing-productivity audit on the HSR activity by determining whether they are being cost effective in meeting their marketing strategies. A review of associated cost data relative

to their actions was undertaken. Secondary data and personal interviews with structured questions (see Appendix M) were utilized.

Stage VIII: Performed a marketing-function audit by evaluating the major marketing mix components used by the HSR activity at DDEAMC. The components evaluated were:

a) Products & services: Value & benefits recognized by the user of our products or services.

b) Price: Costs to the provider or beneficiary for the exchange.

c) Place: Time, distribution and location of service delivery.

d) Promotion: Communications, advertising, public relations, personal selling, direct mail.

Each component underwent review to determine where problems could be solved or opportunities could be capitalized on by manipulating the marketing mixes. Secondary data, personal interviews (see Appendix M), and survey data were utilized in this stage.

Stage IX: Interpreted findings and provided recommendations to DDEAMC and the DCRI for the development of marketing plans for the targeted HSR services. (see Appendix K).

RESULTS

Results of this project are presented in two topical headings. The first heading will cover the Mildred service data results, and the second heading will cover the Consultant service data results.

Mildred Service

The results of the service component audit questions and survey for the Mildred service are provided in summary form. Appendix N lists the percentage breakdown of findings from the survey. Results are given based on each stage of the research methodology for this project (omit stages I., II., and IX):

Marketing Environmental Audit:

(DEMOGRAPHICS)

The demographics associated with provider trends and patient trends are not monitored. Demographic studies are not made to observe possible future impacts on the Mildred service.

(ECONOMICS)

Economically, Mildred services may increase in demand due to the increase in CHAMPUS rates. On the other hand, demand for the Mildred service is expected to decline as partnerships increase in number near MEDDACs. No significant economic changes in funding for the Mildred services are expected to occur.

(TECHNOLOGIC)

Two forms of technology will be impacting the Mildred service. One form is the advancing technological capabilities of DDEAMC in the open heart program. The open heart program will prompt an increase in follow-up referral appointments which may increase Mildred services. The other form is the magnetic reasonance imager (MRI) technology which has recently been implemented at DDEAMC. The MRI is expected to increase the demand for Mildred services because MEDDACs do not have it and the civilian prices are higher.

(POLITICAL)

Uniform governmental policies concerning MEDICARE reimbursement and third party collection at military treatment facilities may increase Mildred services or decrease Mildred services. No concrete determination can be made until these policies become law.

Force reduction may affect MEDDAC staffing levels and therefore require a greater number of referrals via Mildred services.

(CULTURAL)

Cultural factors such as familiarity and satisfaction with the Mildred service were sampled by survey. 100 percent of the health care facilities within the DDEAMC HSR responded to the survey. See appendix N for satisfaction and familiarity data.

(MARKETS)

Mildred services are tracked in the following manner:

a) Number of patient appointments per month.

b) Number of telephone assistance calls per month.

c) Number of inpatients per month.

No cyclic trends seem to be occurring, and increases and decreases appear random.

(PROVIDERS)

There are currently no rating nor surveying mechanisms in place which would enable physicians to rate the quality and reputation of Mildred services.

The decision to use Mildred services is based on the clinical demand to receive tertiary care for their

patients. Medical resource shortages also play a role in the decision-making process of the MEDDAC provider.

(COMPETITORS)

Mildred services do not have competitors. Mildred is a service that has been implemented because the normal DDEAMC patient referral system in place cannot manage the demand. Mildred services can act as a health care finder, problem solver, or discharge planner when the need arises within the HSR. Survival of Mildred services does not rest with the competition. Survival of Mildred services depends on the condition of DDEAMC's tertiary care patient appointment referral system.

(DISTRIBUTION AND DEALERS)

The main channel for service delivery of Mildred is the Department of Primary Care and Community Medicine (DPCCM). The main coordinator is the Health Systems Assistant (GS-7). The health systems assistant works directly for the C, DPCCM. The C, DPCCM is the main marketer of the Mildred service to the HSR.

Growth potential for the Mildred service is not recognized by the staff since it is a service which covers a "gap" in DDEAMC's health care delivery. The role of Mildred is expected to pass on to the "Gateway

to Care" program -- in the form of a health care finder.

(SUPPLIERS)

Key resources for Mildred are the DDEAMC physicians, the DDEAMC coordinator, the ambulance service, central appointments, and the phone system. Physician interest in Mildred needs to be emphasized to assure there is patient access to tertiary care. Staff coordination for Mildred services at DDEAMC appears admirable since the survey revealed no Mildred coordinator complaints (survey). Ambulance coverage for Mildred appears adequate (survey). Immediacy and availability of appointments at DDEAMC for MEDDAC tertiary care referrals needs to be restructured (survey). Phone systems are inadequate to meet needs of the HSR (survey).

Under this paragraph, no specific provider trends associated with their health care delivery are noted.

(FACILITATORS AND MARKETING SERVICES)

Transportation and financial services are not detailed for direct support of marketing Mildred services to the HSR.

Currently, the HSR marketing effectiveness can be measured by the percentage of MEDDACs and health

clinics who are "very familar" and "somewhat familiar" with the Mildred services. The effectiveness for that would equate to 50 percent.

(PUBLICS)

The providers who use the Mildred services are the most important public. The MEDCEN & MEDDAC providers offer the opportunity to assure access to care for the patient. The MEDCEN & MEDDAC providers could become a problem for Mildred services if they do not understand the role of Mildred services. Their lack of understanding could have an affect on resource efficiencies or on interhospital relations. To maximize the patient access to care opportunity and to minimize the problems associated with misunderstanding, Mildred service issues are discussed quarterly at the Triservice Conferences.

Marketing Strategy Audit:

(BUSINESS MISSION)

No formal mission statement exists addressing the Mildred services. Descriptions of the patient facilitation process (Mildred) exist as follows:

a. A portal of entry to regional military health care.

b. The embodiment of facilitated access to concerned regional care.

c. The incorporation of discharge planning into the total treatment plan.

No formal mission statement exists because Mildred services are a reactive means to cover the gaps existing in the DDEAMC tertiary care referral system.

(MARKETING OBJECTIVES)

Formal marketing objectives do not exist for the Mildred service. Marketing objectives within the strategic plan are geared to reflect the broad needs of the DDEAMC HSR, i.e. marketing the DDEAMC regional role, marketing DDEAMC's patient support capacity, or marketing DDEAMC's image to the region, etc.

Under this paragraph, no performance measureable nor resource sensitive objectives exist for the Mildred service.

(STRATEGY)

No core marketing strategy exists for the Mildred service. Therefore, objectives are not resourced, targeted, nor based on a marketing mix (service, place, price, promotion).

Marketing Organization Audit:

(Formal Structure)

There is no formalized marketing officer for the Mildred services. Mildred services are ad hoc in nature and are marketed at a minimum.

Marketing of Mildred services is not performed along functional lines.

(FUNCTIONAL EFFICIENCY)

In the DDEAMC HSR, the coordinator of the Mildred services & the marketers of the Mildred services are the same people.

Market training for the coordinator of the Mildred service is needed. Coordinator familiarity with some basic marketing concepts could improve interhospital relations.

(INTERFACE EFFICIENCY)

No major problems have surfaced between the minimal marketing of Mildred services and DDEAMC staff.

Marketing Systems Audit:

(MARKETING INFORMATION SYSTEM)

There is no marketing intelligence system in place at DDEAMC that provides accurate, sufficient, and timely information about market place developments. Mildred demand is followed by monthly reports of assistance phone calls, patient tertiary care referral visits, and ambulance runs. There is no elaborate marketing information system in operation - - there is only manual monitoring by Mildred coordinating staff.

(MARKET PLANNING SYSTEM)

Since Mildred is a reactive means to cover the gap in health care delivery, a market planning system for Mildred services is not applicable. The improvement of the patient tertiary care referral process at DDEAMC is a strategic plan issue.

(MARKET CONTROL SYSTEM)

Since there are no marketing objectives for Mildred services, control measures for marketing objectives do not exist.

Mildred services is not observed by the coordinating staff as a service which may be discontinued due to low returns to DDEAMC. Mildred services is observed as an obligation to ensure access to care. For example, Mildred services average 44 appointments a month with a monthly average inpatient

return of 3 for DDEAMC. Additionally, the workload generated and manpower involved in managing Mildred are not segregated with identification codes to allow scrutiny.

(NEW SERVICE DEVELOPMENT SYSTEMS)

This paragraph does not apply to the Mildred services specifically. The DCRI office which coordinates a majority of the HSR activity, does have access to DDEAMC's Clinical Research & Investigation equipment and staff in order to allow for studies involving new services. Additionally, DDEAMC RMD has staffing which can perform cost-benefit studies if required.

Marketing Productivity Audit:

(PROFITABILITY ANALYSIS)

DDEAMC receives a public relations profit from the Mildred services. This public relations profit binds the regional community to work closer.

Obviously, the workload generated from Mildred Services generates a MCCU form of profit to DDEAMC. On the monthly average Mildred services covers 44 visits, 3 inpatient admissions, and 188 patient assistance calls. Compared to monthly productivity at DDEAMC,

Mildred services provides 0.23 percent of the inpatients and 0.10 percent of the outpatient visits.

Another form of profit generated is the ability of DDEAMC to collect third party health care insurance.

Strategic planning for Mildred services has not been a consideration due to its reactive role.

(COST EFFECTIVENESS ANALYSIS)

Mildred services are not monitored for direct costs to operate. Manpower data is available, but it is not valid nor reliable. The manpower data is completely integrated with other mission requirements in DPCC&M.

Marketing Function Audit:

(SERVICES)

There are no formalized written objectives for the Mildred service. Per discussion with coordinators of the Mildred service, the following objectives could be assumed:

a. To serve as a facilitation process for tertiary care when normal access fails to adequately respond.
b. To serve as a component in the discharge planning program should there be a need.

These latter objectives are routinely being met by DDEAMC.

Mildred services are reviewed at the coordinator level, the command level at the executive committee, and at Army MEDDAC commander's conference level quarterly.

Mildred services provide the following for the HSR:

a. Facilitates access to tertiary care.
b. Supports discharge planning program.
c. Opens communication channels between facility providers.
d. Reinforces public relations between facilities.

The description of Mildred services, as provided by the DDEAMC coordinator is the following:

Mildred is a portal of entry to regional military health care, the embodiment of facilitated access to concerned regional care, and the incorporation of discharge planning into the total treatment plan.

There is no feedback mechanism in place to allow the DDEAMC providers and MEDDAC providers to make

judgements or recommend improvements in the quality, the feature, or the style of the Mildred services.

Over 60 percent of the respondents in the survey identified competition for DDEAMC tertiary care services as their local partnerships, local regional hospitals, local health care contracts, or local CHAMPUS accepting providers. Rationale for choosing the competition over DDEAMC is patient convenience, patient illness acuity, geographical distance, waiting time for appointments, communication via a poor phone system, and some providers feel they lose treatment control of the patient once evacuated.

Attention has been given to Mildred services by "identifying a conceptual title." Still lacking in attention is the packaging of the Mildred services due to the 50 percent (survey) lack of familiarity with the service from the MEDDACs.

(PRICE)

There are prices incurred by users of the Mildred service. Those prices are:

a. The distance to travel for the patient.

b. The time to wait till treatment.

c. The separation of the attending physician and the patient.

d. The loss of "workload units."

50 percent of the survey respondents ranked "very satisfied" to "somewhat satisfied" for Mildred services. This ranking could be interpreted as an approximate value acceptance of Mildred services with the current "prices" they incurred.

The "prices" incurred by the MEDDACs are not associated with the direct exchange of money as in the civilian sector. To equate the "prices" MEDDACs incur would not be applicable to advertising the lowest prices, to meeting the competition's prices, or to establishing prices by analysis of demand.

(PLACE)

There are no distributional objectives nor distributional strategies formally established for Mildred services. Essentially, the Mildred service is received from DDEAMC. Distribution of the Mildred service begins with the coordination initiated between MEDDAC staff and DPCCM staff.

Mildred services cover that part of the DDEAMC market share which is not covered due to patient

referral system flaws. Therefore, it is not conventional to think of DDEAMC's Mildred services gaining that extra marketshare.

Since Mildred services is a newly established service, research has not been undertaken to determine whether "alternate sites" or "alternate time periods" would improve access or satisfaction.

(PROMOTION)

There are no formalized advertising objectives. Informal objectives are the following per observation of the student:

a. To develope the concept "Mildred" for marketing to the DDEAMC HSR.
b. To introduce the Mildred service as a patient facilitation process to the HSR.

These informal objectives seem to be appropriate and have attained a "very familiar" to "somewhat familiar" ranking of 50 percent from the respondents of the survey.

There is no established advertising budget for the Mildred service. Additionally, there is no recognized budget for the overall Mildred services operation.

Some of the Mildred services promotional activities or media have been the following:

a. The development of slides explaining the Mildred service.
b. The presentation of Mildred services to the HSR health care facilities at the quarterly Army conference sessions.
c. Word of mouth advertising by DDEAMC coordinators of the Mildred services capabilities.
d. The delivery by mail of Mildred services information upon request.

No well conceived publicity program exists for Mildred services. The 50 percent ranking of "very familiar" to "somewhat familiar" by respondents of the survey provides some validity to the latter comment.

DDEAMC staff do not directly seek out persuasive measures nor incentives for motivating MEDDAC staff to utilize Mildred services. It is assumed that some of those incentives are:

a. The quality of tertiary care at DDEAMC.
b. The MEDDAC dollars saved in supplemental care.
c. The higher likelihood of scheduling a patient for an appointment.

d. The cost shares saved for the CHAMPUS or MEDICARE eligible patients.

Consultant Service

The results of the service component audit questions and survey for the Consultant service are provided in summary form. Appendix N lists the percentage breakdown of findings from the survey. Results are given based on each stage of the research methodology for this project (omit stages I. and II.):

Marketing Environmental Audit:

(DEMOGRAPHICS)

The demographics associated with provider trends are not monitored. The demographics of the beneficiary population of the region by state are reviewed routinely. The beneficiary demographics are provided by the Defense Medical Information System (DMIS). The Demographic reviews are not made to observe possible future impacts on the Consultant service.

(ECONOMICS)

Economically, Consultant services are expected to increase in demand due to the increase in CHAMPUS rates. On the other hand, demand for the Consultant service is expected to decline as partnerships

increase in number near MEDDACs. Since the consultants also seek "graduate medical education" (GME) patients, a decrease in their demand could be detrimental to DDEAMC's residencies. No significant economic changes in funding for the Consultant services are expected to occur.

(TECHNOLOGIC)

Two forms of technology will be impacting the Consultant service. One form is the advancing technological capabilities of DDEAMC in teleradiology, which will reduce need for consultant visitation. The other form is the use of teleconferencing, which will reduce the need for consultant visitations. Both teleradiology and teleconferencing may not diminish the need for consultants -- only the requirement to actually visit the MEDDAC.

(POLITICAL)

Uniform governmental policies concerning MEDICARE reimbursement and third party collection at military treatment facilities may increase Consultant services or decrease Consultant services. No concrete determination can be made until these policies become law.

Force reduction will affect MEDDAC staffing levels and therefore require a greater number of consultant visits to the MEDDACs.

The gradual reorganization of Health Services Command at San Antonio (to the Office of the Surgeon General) may prompt an increase in the activities of the Consultant services. This is a perception of the DCRI at DDEAMC, who sees the role of regional military hospitals growing as further staffing efficiencies are realized. Consultants services may be the channel to allow for the decentralization of some command responsibilities at HSC and therefore develop staff management efficiencies.

(CULTURAL)

A cultural factor such as satisfaction with the Consultant service was sampled by survey. 100 percent of the health care facilities within the DDEAMC HSR responded to the survey. See appendix N for satisfaction data.

(MARKETS)

Consultant services are loosely tracked/monitored in the following manner:

a) Number of Regional consultant visits per month.

b) Number of mandays per month per MEDDAC/Clinic.

c) Record of conditions requiring delay or cancellation of regional visits.

d) Review of Consultant after-action reports.

The monthly demand for Consultant services is a product of the flights (each MEDDAC) prescheduled three months prior, the variable requests from each MEDDAC, and the initiative of the consultants.

(PROVIDERS)

There are currently no rating nor surveying mechanisms in place which would enable MEDDAC physicians to rate the quality and reputation of Consultant services.

The DCRI routinely reviews after-action reports submitted by the returning consultants. As a result of the DCRI's reviews, changes to the consultant services program may be initiated. The DCRI also reviews the executive committee minutes of each MEDDAC to monitor HSR services which includes the Consultant services.

The decision to request Consultant services is based on the clinical demand, resource shortages, and the "continuing medical education" (CME) needed at the DDEAMC HSR facilities.

(COMPETITORS)

Consultant services in the literal sense do not have competitors. Survival of the Consultant services does not rest with the competition. Some of the activities which act somewhat as a form of competition are CHAMPUS and U.S. Airforce Medical Center, Keesler. CHAMPUS gives geriatric, or special case beneficiaries the choice to use civilian health care facilities which therefore reduces the selection of teaching cases that are needed in DDEAMC's GME. Keesler in Mississippi has competing residencies requiring GME quotas and in some cases has pulled DDEAMC bound patients to their facility.

(DISTRIBUTION AND DEALERS)

The main channel for service delivery of the Consultant services is the office of the Deputy Commander for Regional Integration (DCRI) at DDEAMC. The main coordinator is the DCRI's secretary (GS-6). The DCRI is the main marketer of the Consultant service to the HSR.

Growth potential for the Consultant services appears very positive for the region. There are strong expectations that the role of DDEAMC consultants and the roles of the HSR MEDDACs/health clinics will be thoroughly integrated. Integrated to the degree that a "Regional Office" will have command influence i.e.

manage funding decisions, and affect patient flow patterns. This increased integration will prompt greater consultant activity and growth potential.

(SUPPLIERS)

Key resources for the Consultant services are the DDEAMC consultant appointed physicians, the DCRI secretary, the military flight services, and the teleconferencing system at Fort Gordon. The outlook for these key resources appears positive, since GME, CME, and tertiary care demands should always be a demand in the patient care ecosystem.

Specific DDEAMC consultant trends are not monitored by statistical analysis. After action reports are prepared by each consultant and reviewed by the DCRI. A courtesy copy of the report is sent back to the MEDDAC/health clinic visited.

(FACILITATORS AND MARKETING SERVICES)

Transport of the consultants is primarily by military aircraft (C-12 & U-21). The military flights are not costed to DDEAMC. POV travel is an option to the consultants and a per diem fund account of $10,000 dollars is annually provided. Per diem total costs are currently at $2900 dollars (FY 91). Currently, the HSR marketing effectiveness can be measured by the

percentage of MEDDACs and health clinics who are "very familiar" and "somewhat familiar" with the Consultant services. Marketing effectiveness per the survey would equate to 80 percent.

(PUBLICS)

The providers who serve as consultants are the most important public. The consultants offer the opportunity to assure patient access to care, to ensure CME to the MEDDACs, and to ensure the appropriate GME is attained at DDFAMC.

The MEDCEN & MEDDAC providers could be problems for the Consultant services if they do not understand the role of the services. Their lack of understanding could have an affect on resource efficiencies or on interhospital relations. To maximize the patient access to care opportunity & to minimize the problems associated with misunderstanding, Consultant service issues are discussed quarterly at the Triservice Conferences, and monthly at the DDEAMC executive committee.

Marketing Strategy Audit:

(BUSINESS MISSION)

In the FY 90 Strategic plan for DDEAMC, there is the following mission statement:

To serve as Regional Director for HSC, providing quality control in the day-to-day evaluation and conduct of the delivery of care in the Southeastern United States and the Caribbean Basin, and to serve as Regional Coordinator, in conjunction with the USAF and USN, for DOD Region VII.

The Consultant services marketing aspect is recognized in the latter statement which indicates that DDEAMC is the "Regional Director" and "Regional Coordinator" for health care in the Southeastern United States.

The description of the Consultant services is further defined in a document (provided to active consultants) outlining the responsibilities of the consultant. The document covers the following:

a. The consultant's responsibility to the DDEAMC commander is to assist in reviewing the quality of care practiced at the the MEDDACs. This assistance is in the form of risk management, credentialling, and utilization management/review.

b. The consultant's responsibility to the DDEAMC commander is to monitor all aspects of medical officer distribution (their specialty) annually and

to work with the Surgeon General's consultants & Health Service Command on medical officer distributions.

c. The consultant's responsibility to the DDEAMC commander is to be knowlegeable of health care delivery practices in the region. The consultant should be knowlegeable in the successes & problems involved with interhospital communication and transport, in beneficiary trends, in referral patterns, in effective specialist utilization, and in the integration of health care services.

d. The consultant's responsibility to the MEDDACs is to play an active role in their quality assurance programs.

e. The consultant's responsibility to the MEDDACs is to be proactive in managing medical personnel assets when critical shortages occur or when medical coverage is needed to cover medical officer TDYs.

f. The consultant's responsibility to the specialists in the region involve identifying regional accomplishments, assisting in junior officer

development, conducting training (on rounds, CME), and providing direct patient consultations.

(MARKETING OBJECTIVES)

Formal marketing objectives exist for the Consultant service in the DDEAMC FY90 Strategic Plan. The marketing objectives are listed under the following goal statement for the region:

> A command which supports HSC, DA, and DOD as a solidifying and coordinating element in the delivery of quality health care and integration of all triservice medical elements in the Southeastern United States, Puerto Rico, Panama, and the Caribbean Basin.

Which specifically are:

a. To develop a mission for regional responsibilities. This objective contains marketing tasks such as establishing regional consultants (clinical, allied health & administrative) & defining their roles, obtaining input from other MTFs in the region for planning, and developing an Army regional services network.

b. To obtain adequate resources for the regional mission. This objective contains marketing tasks such as establishing authorizations for the DCRI office, expanding TDY funds to support regional missions, and performing cost studies of regionalization involving man-days & man-hours.

c. To assist with the allocation of resources and

requirements within the region. This objective is focused on expanding DDEAMC's regional responsibilities.

d. To enhance the patient referral system from the region. This objective includes marketing tasks such as maintaining the consultant visitation program, identifying patients for GME programs, and incorporating regional concerns into the DDEAMC discharge planning program for the region.

e. To improve communications and transportation between regional hospitals and DDEAMC. The marketing task included in this objective is targeted to improve telephone communication between DDEAMC & the region.

f. To achieve market dominance for available services in the region. The marketing task included in this objective identifies utilizing the consultant staff to influence appropriate referrals for the DDEAMC GME program.

g. To market the regional role of DDEAMC as a DOD tertiary care facility . This objective includes the task of marketing the capabilities and image of DDEAMC to the MTFs in the region.

h. To involve the Army MTFs in the region with the annual strategic planning process. A majority of the objectives within the strategic plan are geared to reflect the broad needs of the DDEAMC HSR, but several other objectives (above) do indicate a marketing aspect having some form of impact on the Consultant services at DDEAMC.

(STRATEGY)

No core written marketing strategy exists for the Consultant service, although there are formalized marketing objectives. The lack of a formalized marketing strategy indicates to the auditor that each particular objective is not resourced specifically. Per discussion with DCRI staff and RMD staff,

objectives are not resource targeted nor based on a marketing mix (service, place, price, promotion) priority.

Marketing Organization Audit:

(FORMAL STRUCTURE)

There is no formalized marketing officer for the Consultant services. The DCRI and his secretary (GS-7) carry out various parts of the market mix at varying degrees of attentiveness. Examples of the DCRI office marketing efforts are outlined under the marketing function audit of this project.

Organized marketing of the Consultant services is not performed along functional lines. Although, any contact with the consultants at DDEAMC, by phone or correspondence, would constitute a form of functional line marketing.

(FUNCTIONAL EFFICIENCY)

In the DDEAMC HSR, the coordinators of the Consultant services & the marketers of the Consultant services are the same person.

Market training for the coordinator of the Consultant service is not needed. The DCRI's

familiarity with marketing and his configuration of the strategic plan for regional integration verify his marketing knowledge.

(INTERFACE EFFICIENCY)

No major problems have surfaced between the marketing of Consultants services and DDEAMC staff. Command support for the efforts of the DCRI is very strong.

Marketing Systems Audit:

(MARKETING INFORMATION SYSTEM)

There is no marketing intelligence system in place at DDEAMC that provides accurate, sufficient, and timely information about market place developments for the Consultant services. The Defense Medical Information System (DMIS) is used to review the demographics of the beneficiary population. Consultant demand is followed by monthly reports of consultant visits, miscellaneous problems with air flight coordination, review of consultant after-action reports and manhours expended by DDEAMC consultants. There is no elaborate marketing information system in operation - - there is only manual monitoring by Consultant services coordinating staff.

Marketing research is not being used by the DCRI office to make decisions about the Consultant service. Demand is driving decisions based on patient acuity, GME, and lack of tertiary care specialities.

(MARKET PLANNING SYSTEM)

The Consultant services are a component in the DDEAMC Strategic Plan under the regionalization program. As a result, market planning for the Consultant services is annually a part of the Strategic Planning Conference. Data is collected on the manhours expended by the consultants at the HSR facilities. This data is used to validate present and future demand for Consultant services.

(MARKET CONTROL SYSTEM)

The Regional marketing objectives accomplished or in progress (DDEAMC Strategic plan) for the Consultant services are monitored personally by the DCRI. The DCRI modifies these objectives as needed. The controlling system for the marketing objectives is essentially a human element, the DCRI. Cost analysis by the DCRI has not been a management tool for the Consultant services.

(NEW SERVICE DEVELOPMENT SYSTEMS)

This paragraph does not apply to the Consultant services specifically. The DCRI office which coordinates a majority of the HSR activity, does have access to DDEAMC's Clinical Research & Investigation equipment and staff in order to allow for studies involving new services. Additionally, DDEAMC RMD has staffing which can perform cost-benefit studies if required.

The channel for new regional services, under consideration, are presented at the Quarterly Army Conference and the DDEAMC Executive committee before implementation.

Marketing Productivity Audit:

(PROFITABILITY ANALYSIS)

The profit received by DDEAMC from the Consultant services operation is not in the form of direct dollar exchanges. For example, DDEAMC receives a public relations profit from the Consultant services that binds the regional community to work closer. Another form of profit for DDEAMC is the exceptional GME cases drawn into its residencies by the consultants.

The professional development of DDEAMC's consultants is an indirect profit. The consultants professional development is enhanced by practicing medicine and performing CME classes.

Currently, third party medical insurance collection procedures can be initiated for those inpatient cases (GME & referrals) directed to DDEAMC. These cases can therefore be considered a form of profit for DDEAMC operations.

The workload generated by the patient referrals to DDEAMC serves as verification to higher headquarters for increased funding (MCCUs). This workload can be considered a form of profit to DDEAMC.

On a case by case basis the DCRI becomes the key analyst in determining what parts of the Consultant service could be expanded, contracted, or terminated. This determination by the DCRI is followed by Executive Committee and Army conference presentations/review. The short term and long term impact, if applicable, of these determinations is reviewed.

(COST EFFECTIVENESS ANALYSIS)

Consultant services are not monitored for direct costs to market. For instance, some consultant manpower costs are tabulated as man-hours expended (DCRI office), other manpower costs are based on the receipt of TDY documents which keys DDEAMC manpower personnel to tabulate expenses (RMD), and some are either supply or TDY expense compilations. Because

several other mission requirements of the HSR operation are integrated into these cost/expense reports a cost effectiveness analysis specific for marketing is not possible with the current cost management configuration.

Marketing Function Audit:

(SERVICES)

There are marketing objectives located within the DDEAMC FY90 Strategic plan that concern the Consultant services. These objectives are located under the Regional goal statement (see under Marketing Strategy Audit: Marketing Objectives).

Some of these marketing objectives have been met for example, the "consultants roles" have been identified and they do have written "responsibilities". While some of these marketing objectives have not been met, for example, the MTF coordinated development of an "Army regional services network involved in regional planning" or the "improvement of the phone system in the region".

It is very normal in marketing plans to have some objectives met, some objectives ongoing, or some

objectives failing. The marketing objectives for the Consultant services overall appear to be within the norm.

Consultant services are reviewed at the DCRI level, the command level (executive committee), and at Army MEDDAC commander's conference level (quarterly). The latter reviewing levels could result in the phasing-in or phasing-out of certain aspects of the Consultant services.

The provisions and description of the Consultant service are covered for this project under the "Market Strategy Audit" paragraph subtitled "Business Mission."

There is no formal feedback mechanism in place to allow the DDEAMC providers and MEDDAC providers to routinely make judgements or recommend improvements in the quality, the feature, or the style of the Consultant services.

The following survey results in "total percents" could indicate that the Consultant services is a satisfying service for a majority of the MTFs in the Army HSR: 10 percent Very satisfied, 70 percent Somewhat satisfied, 20 percent Neither satisfied nor unsatisfied, 0 percent Somewhat unsatisfied, and 0 percent Very unsatisfied.

Tremendous attention has been given to the identity development and packaging of the Consultant services by the creation of a regional symbol (see Appendix O), by the DCRI's repeated efforts to establish an authorized DCRI office, and by the development of a Strategic plan with marketing objectives.

(PRICE)

The MEDDACs or health clinics who use the Consultant service can only benefit. Price would not be a major deciding factor for the MEDDAC. Because the Consultant services teach providers (CME), produce local workload, or render tertiary care to MEDDAC beneficiaries.

The possible prices may be the time spent attempting to communicate by phone to coordinate the Consultant visits, or the possibility that weather may play a role in delaying or terminating a visit.

80 percent of the survey respondents ranked "very satisfied" to "somewhat satisfied" for the Consultant services. This ranking could be interpreted as an approximate value acceptance of the Consultant services with the current "prices" they have incurred.

The "prices" incurred by the MEDDACs are not associated with the direct exchange of money as in the

civilian sector. To equate the "prices" MEDDACs incur would not be applicable to advertising the lowest prices, to meeting the competition's prices, or to establishing prices by analysis of demand.

(PLACE)

There are no distributional objectives nor distributional strategies formally established for the Consultant services. The Consultant services essentially are distributed from each MEDDAC/health clinic. If distributional objectives are to be developed, they should be developed at the MEDDAC /health clinic level.

To determine whether the Consultant services provide adequate market coverage for each MEDDAC location would require ten different market research projects. This will possibly become a recommendation for MTFs in the region.

Research has not been undertaken to determine whether "alternate sites" or "alternate time periods" would improve satisfaction.

(PROMOTION)

There is a formalized advertising objective which indicates the need to market DDEAMC's Regional role to the MEDDACs/health clinics in the region. Specific

tasks characterize this advertising focus to be on DDEAMC's image & capabilities.

There is no established advertising budget for the Consultant service. A supply budget of $400.00 dollars a year has been used to meet advertising demands. Some of the Consultant services promotional activities or media have been the following:

a. The development of slides explaining the Consultant service.
b. The presentation of Consultant services to the HSR health care facilities at the quarterly Army conference sessions.
c. Word of mouth advertising by DCRI staff.
d. The delivery by mail of correspondence related to the Consultant services.
e. Teleconference sessions on a routine basis with MEDDAC/health clinic staff and commanders.

Because of normal consultant demand, no well conceived publicity program exists for the Consultant services. Normal demand is defined as CME, GME, provider shortages, tertiary care demands, clinical investigations, or peer reviews.

Becoming a consultant is a distinguished honor. Final selection rests with the DCRI, DDEAMC commander, and members of the HSR. A certificate is presented to the members selected for consultant status in the region. The honor involved with this status serves as the incentive for providers or administrators.

DISCUSSION OF FINDINGS

Due to the qualitatively focused questions outlined in the "service component audit (SCA)" for both services, a certain degree of discussion has already taken place within the "Results" chapter of this project. Also integrated into the results chapter were findings from the survey (see Appendix N).

It is worth noting at this point that the methodology stages III - VIII were covered in the results chapter. Stage IX will be a composite of the subsequent chapters to follow.

The discussion surrounding the findings will be introduced to the reader in two parts. The first discussion will address Mildred services, and the second discussion will address Consultant services.

Mildred Services

Kotler's (1984) format for a marketing audit provided the findings needed to establish a marketing evaluation for the service. The comprehensive audit format addressing environment, strategy, organization, systems, productivity, and function, appears to be very thorough in providing a marketing evaluation.

For instance, the marketing environmental audit revealed weaknesses and strengths in marketing the Mildred services. Weaknesses observed were the following:

a. No demographic studies are being implemented. A portfolio of the public using the service should be created to best forecast future demand.

b. Satisfaction and familiarity with the service rank a 60 percent and a 50 percent rating respectively. This data reveals a lack of marketing effort.

c. No established system is in place which routinely obtains input from users of the service. Services should seek the perceptions of their users to make improvements and increase satisfaction.

d. The service is a means of taking care of a problem associated with the institutions patient referral

system. Perhaps the overall patient referral system should undergo realignment to be most effective.

Strengths observed were the following:

a. The service's staff are aware of the external managed care programs and politics which could effect them.

b. The service's staff is aware how new technology available at DDEAMC may influence the service.

c. The service is tracking demands on the service.

d. There is an organized office for the service to operate from.

In evaluating the data obtained from the marketing strategy audit the student found the following:

a. A definition for the service exists but there is no business mission, formal marketing objectives, nor core marketing strategy in place.

b. No established resourcing for the service is organized.

The lack of formalized marketing objectives and strategies at this point in the research should have signaled to the student that perhaps market research into this service was not needed. The issue of whether market research should be considered will be covered in a later paragraph within this discussion section, in accordance with Zikmund (1989).

Other audit findings revealed additional marketing shortcomings. There essentially was no marketing system in place nor a formalized marketing officer. As a service the comparative productivity was very low, i.e. 0.23 percent of the inpatient visits, and 0.10 percent of the outpatient visits on a monthly average. Also when reviewing the functional audit findings, familiarity with the service was quite low at 50 percent.

Zikmund's Test: By taking the approach Zikmund (1989) would have used prior to performing market research, a great deal of time and effort could have been saved by the student.

In reviewing the findings in accordance with Zikmund's "research needed formula" (see Appendix E), Mildred services would not qualify as a service requiring marketing research efforts. For instance, using appendix E, the initial two questions could be

answered with a "Yes" because time is available, and the information on hand about the service is inadequate. A "No" would be the response for the next two questions which address whether the service carries considerable strategic importance, and whether the research information exceeds the cost of the conducting the research.

Validity and Reliability of Findings:

Internal validity per Campbell and Cook (1979), for the survey data (see appendix N) was threatened due to the indirect time constraints brought on by the conflict in Kuwait (Desert Storm), the completion of the survey in an uncontrolled environment, and the design of the survey which did not preclude confusion.

External validity as a result of the threats associated with internal validity could be questionable for robust HSR generalizations. In the opinion of the student, findings from the survey are in agreement with perceptions from the DDEAMC staff, and should therefore be admissable for tentative generalizations.

The qualitative design of the project involved a great deal of interpretation left up to the student, e.g. open ended questions from the audit and survey. Therefore, if a weakness in this project is to be

noted, then it would best be directed in the reliability or repeatability of the results interpreted from the survey data or the informal interviews.

Feasibility for a Marketing Plan:

The Mildred service plays a very political role in the HSR in that it provides a special patient facilitation service when the normal patient referral system fails. Although the service's current degree of productivity does not make it a major breadwinner for DDEAMC, its presence creates a statement (to MEDDACs) that if called upon, "personal service" is available.

The development of a marketing plan for such a service as Mildred services is impractical, per Zikmund (1989). To be practical, current patient referral systems at DDEAMC need to be realigned to meet demand before the creation of new enhancing services.

Consultant Services

As with Mildred services, Kotler's (1984) format for a marketing audit provided the findings needed to establish a marketing evaluation for the service. The comprehensive audit format addressing environment,

strategy, organization, systems, productivity, and function, appears to be very thorough in providing a marketing evaluation.

For instance, the marketing audit revealed weaknesses and strengths in marketing the Consultant services. Weaknesses observed were the following:

a. The demographics associated with providers were not monitored. As a major public in the use of Consultant services, the provider demographic portfolio may reveal some variables which could be useful for drawing correlations.

b. There is no routine surveying of the providers using the service from the region. Although after-action reports are screened, the immediate concerns of the MEDDAC providers may be lost.

c. Services are loosely tracked by visits per month, mandays per month, flight problems per month, and the review of after-action reports. This information is used for reactive purposes, and perhaps if better organized could be used for proactive purposes. A

database could be created with this information which could therefore be used to forecast or validate efforts.

d. There is no formal regional patient referral protocol. A patient referral protocol could prevent competing residencies from pulling patients (in transit) from the DDEAMC HSR. An established patient referral protocol (bylaws), with command emphasis, could give consultants the "actual leverage" they need to make changes or to enact strategies throughout the HSR.

e. A majority of the objectives under the regional section of the DDEAMC FY 90 strategic plan are geared to reflect the broad needs of the DDEAMC HSR, but several other objectives (Results chapter) present marketing concerns. Each objective is not categorized as a marketing objective specifically. Additionally, these objectives lack measurability and a general strategy (action plans) for accomplishment.

f. There is no marketing intelligence nor marketing information system for the consultant service.

Creation of a database that is computer linked to each HSR facility may be a feasible move if regional responsibility grows for DDEAMC.

g. Marketing research is not used by the DCRI staff. The possibility of DDEAMC consultants taking a bigger management role in the region is high. Market research may be the solution for this expanded service management.

h. Cost analysis has not been used as a tool for making decisions for the HSR. It may be prudent for the DCRI staff to tabulate specific costs associated with services provided by the HSR since areas of responsibility may grow.

Some of the strengths observed from the data found through the audit were the following:

a. The demographics of the population served are followed for each state, but no significant correlations have been drawn from this data. Forecasting demand should be a task for the DCRI office.

b. Economically, the DCRI is aware of the effects CHAMPUS rates, managed care programs, and GME, can have on the service. This information should be used when establishing a strategic plan for regional services overall.

c. New technologies such as teleradiology and teleconferencing are making the service more cost effective and more easily marketable to the HSR publics.

d. Politically, the DCRI is cognizant of the variables which will affect the service, i.e. MEDICARE reimbursement, third part collection, force reduction, and the future reorganization of Health Services Command under OTSG. Again, these are variables to be considered when a strategic plan for the region is developed.

e. An 80 percent rating or 8 out of 10 of the HSR Army facilities are satisfied with the service. This rating can be interpreted as a variable in the marketing mix that is very key to the survival and the effectiveness of a service.

f. After-action reports are generated after each consultant visit. These reports are then reviewed by the DCRI, and a courtesy copy is forwarded to the involved facility. This is a very key source of feedback for the DCRI when evaluating the effectiveness the service.

g. The DCRI staff is cognizant of the demands for the service by CME, clinical requirements, and medical resource shortages at the facilities. These are very important variables when developing strategic plans.

h. Growth potential (management role) for the service appears very certain when considering the termination of HSC, and force reduction.

i. There is a well established consultant transport system. There is the choice of government flight (no cost to DDEAMC), and the choice of privately owned vehicular transport (under $5000.00 dollars an FY). The versatility of the transport system appears to be a key resource for this service.

j. There is a mission statement for the region which denotes the consultant services role. It is

unfortunate that this role as a regional director and coordinator is not paired with regional bylaws.

k. A description of the consultant's responsibilities is provided in a document provided to authorized consultants. This document establishes a good starting point for new consultants who are curious about their role in the region.

l. The Chief of the DCRI office is well versed in the practice of marketing. He is, however, skeptical of marketing's utility since current operations prompt reactive measures, not proactive measures.

m. Strong support for the service is noted from the command at DDEAMC. The current DDEAMC commander is making efforts to include the Army HSR facilities in the upcoming DDEAMC strategic planning conference.

n. Market planning is an issue in the annual strategic planning conference for DDEAMC.

o. There is a system used by the DCRI staff for making changes or modifications to activities under the

consultant service. The check and balance system used is elevated to two higher levels, i.e. the executive committee, and then the quarterly Army conference.

p. In reviewing the marketing mix (functional audit) for the consultant service, the following is noted:

1. The Consultant service satisfaction rating overall for the region is 80 percent. This finding reinforces the success of the "service".

2. Although there are "prices" incurred by the MEDDACs (distance, poor communication, waiting times, and possible terminations due to weather) the satisfaction rating is still high at 80 percent.

3. "Place of service" is considered a decentralized issue that the MEDDACs/Clinics will need to research in order to maximize its publics satisfaction.

4. "Promotion" receives an "A plus" for the service. A regional symbol has been developed (see Appendix O). A slide presentation outlining the general mission of the consultant service is available. Teleconferencing is maximized for regional services. Objectives in the DDEAMC strategic plan address the need to market the

region's image and capabilities. Although the objectives are at various degrees of accomplishment, the DCRI staff have exercised a great deal of effort to promote the consultant service.

Zikmund's Test:

Using Zikmund's (1989) criteria in determining whether marketing research should be considered (see Appendix E), each question would be answered with a "yes." The consultant service carries enough strategic significance that marketing research is ominous.

It is very obvious that the role of the consultant, as required for regional control /coordination, is very key. The growth potential for the role of the consultant services is quite evident, and it would be very prudent for DDEAMC to have a marketing plan for the service to meet that future state.

Validity and Reliability of Findings:

Internal validity per Campbell and Cook (1979), for the survey data (see appendix N) was threatened due to the indirect time constraints brought on by the conflict in Kuwait (Desert Storm), the completion of the survey in an uncontrolled environment, and the design of the survey which did not preclude confusion.

External validity as a result of the threats associated with internal validity could be questionable for robust HSR generalizations. In the opinion of the student, findings from the survey are in agreement with perceptions from the DDEAMC staff, and should therefore be admissable for tentative generalizations.

The qualitative design of the project involved a great deal of interpretation left up to the student, e.g. open ended questions from the audit and survey. Therefore, if a weakness in this project is to be noted, then it would best be directed in the reliability or repeatability of the results interpreted from the survey data or the informal interviews.

Summary

The student applied the marketing audit approach to two of the HSR services (Mildred service and Consultant service). One of the objectives in this service audit was to use the findings from the marketing audit to develop a marketing plan for the DDEAMC services. A comprehensive review of the audit findings supported the development of a marketing plan for one of the services.

Per the "discussion" chapter, current DDEAMC HSR operations include numerous bits and pieces of the marketing mix (services, price, place & promotion), service components, and exchange relationships that are not recognized as part of a formalized marketing plan. A marketing audit of the unstructured marketing practices at DDEAMC can serve as a base to initiate a marketing plan. It is with this note, that a recommended marketing plan is developed for the Consultant services in the following chapter.

A RECOMMENDED MARKETING PLAN

Bond (1989), and Kotler and Clarke (1987) all agree that a marketing plan is a composite of the objectives geared to minimize weaknesses and optimize strengths within the organization. Their interpretation, in the same respect, provides to the student the initial building blocks to formulate an audit derived marketing plan. The building blocks, in this case, are the weak and strong marketing findings determined in this project.

Kotler and Clarke's (1987) marketing plan format (see Appendix G) was selected by the student for the development of a recommended marketing plan for the Consultant service. The student selected this format

based on Kotler's standing in marketing academia and due to the format's practicality.

A summary of the main goals and recommendations for the Consultant service marketing plan will follow via an executive summary. The major content of the recommended plan (derived from the marketing audit) is provided on appendix P.

Executive Summary

The Consultant services coordinated by the DDEAMC DCRI staff will require the development of a marketing plan that optimizes strengths and minimizes weaknesses. The impetus for the plan is the regional responsibility DDEAMC bears and the expanding managerial role the consultants may play in the reorganization of HSC.

The broad goals of this marketing plan are to orient the service to a marketing perspective and to enhance regional relationships. The objectives associated with meeting these goals are the following:

1. To establish a demographical database indicative of our user publics in the region.

2. To establish a routine survey that evaluates / identifies the satisfaction, the familiarity, and the regional problems applicable to our regional facilities.

3. To develop a formal constitution of Regional Bylaws that the Army HSR must use or refer to when executing regional responsibilities.

4. To establish a database network linkage amongst the HSR facilities for enhancing communications and for compiling key demand/cost data.

5. To resubmit the staff study (to HSC) addressing the addition of manpower to the DCRI Office.

6. To orient the DCRI staff to think of "services" as a marketing mix equation.

This combination of objectives should make the Consultant service more effective and more proactive in providing services to the region.

CONCLUSION

The marketing audit can be used to develop a marketing plan (Kotler, 1984). The audit allows the

researcher to comprehensively review several aspects of a service. Both weak and strong aspects of the service can essentially serve as building blocks for a marketing plan (Bond, 1989). In the case of the DDEAMC Consultant service, the student perceives that the audit approach has provided a "Big Picture" perspective of marketing at DDEAMC, and identified where modifications or additions need to be made. As a result, a marketing plan for the Consultant service has been developed (see Appendix P).

Zikmund (1989) does provide a practical approach in determining whether market research should be applied (see Appendix G). For instance, one of the services reviewed in this project determined marketing research unnecessary, which therefore reflected on the need to develop a marketing plan. Zikmund's criteria for market research should be incorporated into service-type organizations to minimize uneeded marketing efforts.

The utility of the results from this project can serve as a foundation for the establishment of marketing plans or for evaluating the success / failure of a service. Within the dynamics of health care in the military, it would be very prudent for the health care manager to take heed of this utility and closely review the resource exchanges occurring in his

services. The health care organization that can determine its weaknesses / strengths, and adjust its shortcomings to meet the publics needs can find a productive niche in the military health care ecosystem.

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* APPENDICES *
(A - P)

Appendix A

Market Research Format

a) Research objectives and problem definition.

b) Exploratory Research.

c) Formal Survey and / or experimental research (Qualitative approach acceptable).

d) Fieldwork.

e) Data analysis and report presentation.

Source: Kotler & Clarke (1987). Marketing for Health Care Organizations. Prentice-Hall, Inc.

Appendix B

Market Research Format

a) Purpose of the research--Why is the information to be gathered ?
b) Statement of the research objectives--What information is needed ?
c) Review of existing data to discover what is already known.
d) Value analysis--Is the research worth the cost?
e) Research design--How are the data to be collected?
   1.Exploratory
   2.Descriptive
   3.Causal
f) Methods of primary collection
   1.Communication
   2 Observation
g) Research tactics--sampling procedures and instrument design (universe, sample selection, sample size, instrument design, pretesting)
h) Field operations--collection of data
i) Data Analysis
j) Completing the project
   1.Interpreting the data
   2.Recommendations
   3.Report writing

Source: Lovelock & Weinberg (1984). Marketing for Profit and Nonprofit Managers. John Wiley & Sons, Inc.

Appendix C

Relevant Situations for Different Research Strategies or Approaches

Strategy	Form of Research Question	Requires Control	Focuses on Contemporary Event
Experiment	how, why	yes	yes
Survey	who, what where, how many how much	yes	yes
Archival Analysis	who, what, where how many, how much	no	yes/no
History	how, why	no	no
Case study	how, why	no	yes

Source: Yin (1989), Case Study Research. Sage Publications Inc.

Appendix D

Marketing Mix Strategy Variabes

Service: Delivery, logistics, merchandising, management, support, roles.

Product: Developement process, introduction process, positioning, attributes, customization.

Price: Information, process & authority levels, timing of moves, communication.

Promotion: Media selection, support materials, incentives, public relations.

Source: R. A. Garda, (1988). Journal of Marketing.

Appendix E

Determining When Marketing Research Should Be Conducted

Time Constraints	Is there sufficient time available before a managerial decision must be made?
Availability of Data	Is the information already on hand inadequate for making the decision?
Nature of the decision	Is the decision of considerable tactical/strategic importance?
Benefits vs. costs	Does the value of the research information exceed the cost of doing research?

If all questions can be answered "yes," then conduct Marketing Research. If any question is answered with a "no" then Market Research should not be conducted.

Source: W. G. Zikmund, (1989). Exploring Marketing Research. Dryden Press.

Appendix F

Marketing Plan Format

Note: Prior to taking any market research effort, a health care organization should collect and analyze all relevant marketing information (external & internal) already available within the organization.

a) Convene marketing team (Criteria based).
b) Review approaches on initial analysis of project.
c) Prioritize objectives.
d) Identify key target dates for project.
e) Identify all problems and opportunities related.
f) Review market research activities.
g) Initiate and conduct special research projects as required.
h) Concentrate on identification of targets, target analysis, their ranking and sequencing to implementation of the project.
i) Identify exchange and sources of influence that are related to target (publics) organization.
j) Review targets; place in proper sequence for implementation of strategies.
k) Identify internal adjustments needed: staff deployment, policies, service prices.
l) Hold progress report meetings with management to discuss findings, key decisions, and preliminary recommendations.
m) Decide on the tools that must be made to use in implementation.
n) Produce written marketing plan with provision for periodic adjustments.
o) Evaluate effect of strategies at key dates; be prepared to determine measurable results.

Source: Rowland & Rowland, (1984). Hospital Administration Handbook, Aspen Publications.

Appendix G

Marketing Plan Format

---

a) Executive Summary.

b) Situation Analysis (needs/demands).

c) Objectives and Goals.

d) Marketing Strategy (Marketing mix addressed).

e) Action Programs.

f) Budgets.

g) Controls (Continuous Audit of Marketing Effectiveness/Environment).

Source: Kotler & Clarke, (1987). Marketing for Health Care Organizations. Prentice-Hall Inc.

Appendix H

Marketing Plan Format

a) Executive Summary.
b) Situational analysis: External/Internal (Where are we now?).
c) Problems and opportunities.
d) Marketing Program Goals (Where do we want to go?)
e) Marketing Strategies (How are we going to get there?):
   1. POSITIONING: Target segments, Competitive stance, Usage incentive.
   2. MARKETING MIX: Product, Price, Distribution, Marketing communication.
   3. CONTINGENCY STRATEGIES.
f) Marketing budget (How much and where?)...
   1. Resources: Money, people, and time.
   2. Amount and allocation.
g) Marketing action plan:
   1. Detailed breakdown of activities for each goal or strategy.
   2. Responsibility by name.
   3. Activity schedule in milestone format.
   4. Tangible and intangible results expected from each activity.
h) Monitoring system for program and environment.

Source: Lovelock & Weinberg, (1984). Marketing for Public and Nonprofit Managers, John Wiley & Sons Inc.

Appendix I

Marketing Plan Format

a) Situation Analysis

b) Marketing Objectives

c) Marketing Strategies

d) Programs and Schedule

e) Budget

f) Controls

Source: Bond, (1989). Controlling Marketing. Pluribus Press.

Appendix J

Market Audit Service Components

a) A Marketing-environment audit: This audit calls for analyzing macroenvironmental forces and trends in the key components of the company's task environment: markets, customers, competitiors, distributors, and dealers, suppliers, and dealers.

b) A Marketing-strategy audit: This audit calls for reviewing the company's marketing objectives & marketing strategy to appraise how well these are adapted to the current & forecasted marketing environment.

c) Marketing-organization audit: This audit calls for evaluating the capability of the marketing organization implementing the necessary strategy for the forecasted environment.

d) Marketing-systems audit: This audit involves examining the quality of the company's systems for analysis, planning and control.

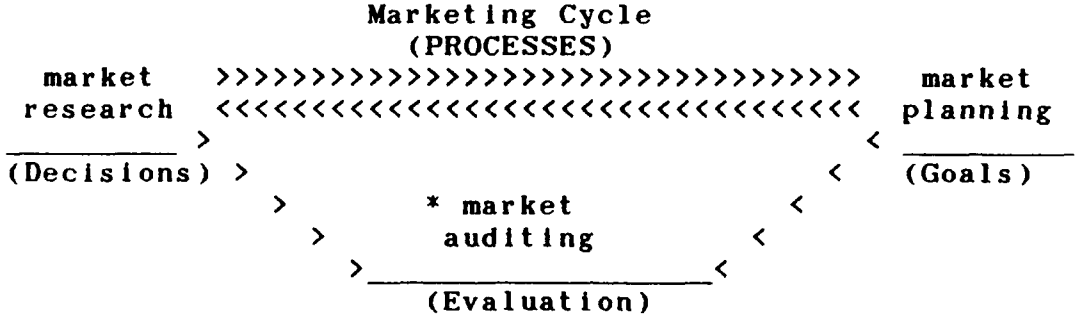
e) Marketing-productivity audit: This audit calls for examining the profitability of different marketing entities and the cost effectiveness of different marketing expenditures.

f) Marketing-function audits: These audits consist of evaluations of the major marketing mix components namely services, products, price, promotion (distribution), advertising and publicity.

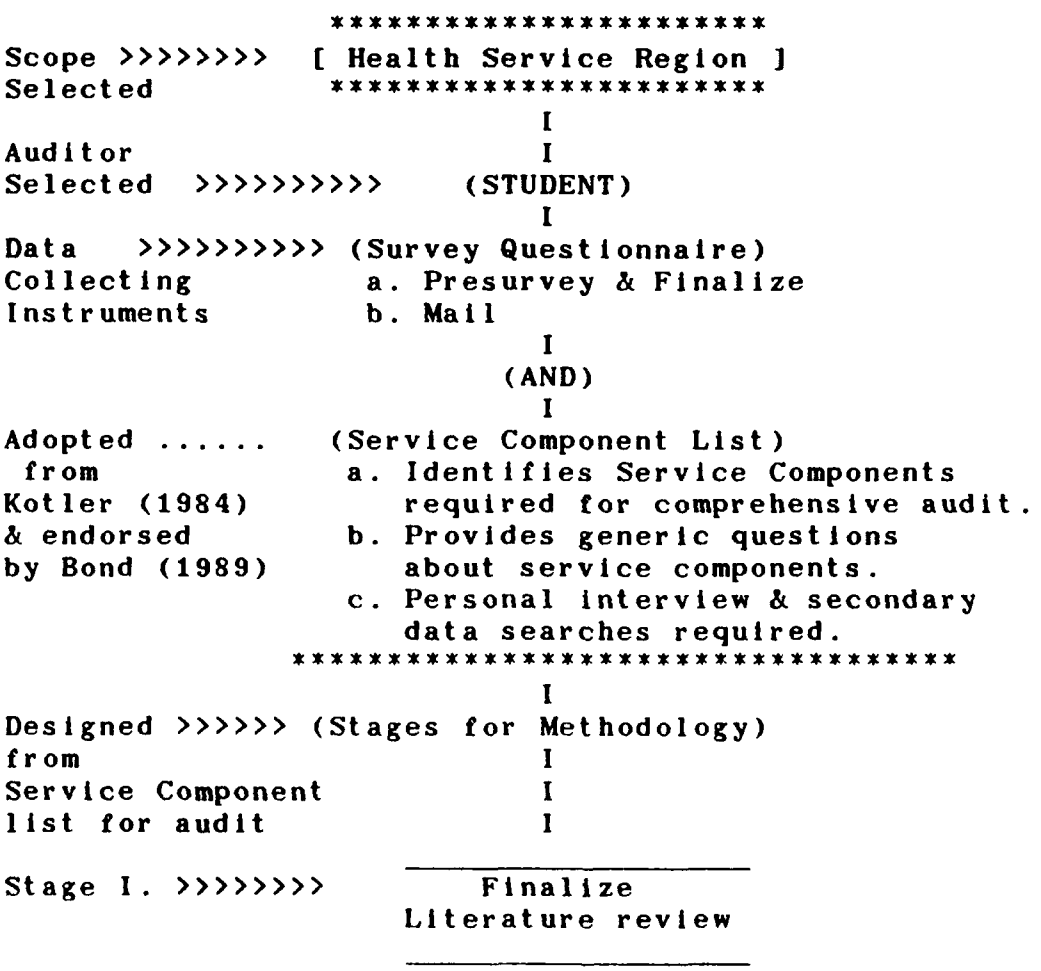
Source: Bond (1989), Barry (1986), Zikmund & D'Amico, and Kotler (1984), See reference list.

Appendix K

Flow Diagram Representing the Methodology and Interface with Marketing Processes



(*) By accessing the marketing cycle at the market auditing process, the following methodology by flow chart takes effect:



Stage II. >>>>>>>> Survey Questionnaire (External Facilities)

Stage III. >>>>>>> to Stage VIII. (more detail see appendix M) Audit format for Service Components:
(1) Environment
(2) Strategy
(3) Organization
(4) Systems
(5) Productivity
(6) Functions (market mix)

Stage IX. >>>>>>>>> Compile findings, Interpret, Discuss, and Recommend to DDEAMC a Marketing Plan for the Health Service Region.

Source: Captain James R. Alarcon (1991). Graduate Management Proposal for Baylor Masters degree in Health care administration.

Appendix L

Survey Questionnaire
(Sample)

QUESTIONS for Deputy Commanders of Clinical Services (DCCS), or Equivalents within the DDEAMC Health Service Region:

Please understand that the responses to the following questions are to evaluate Marketing Practices at DDEAMC concerning the Health Service Region (HSR) and to improve the exchange relationships with each MEDDAC. The information will be used in a Graduate Management Project for the U.S. Army-Baylor Program by (Health Care Admin. Resident) **Cpt. James R. Alarcon**, who can be reached at **AVN: 780-7952**. Data obtained from the following questions will be addressed in the project as e.g. DCCS at Fort Benning MEDDAC revealed that...etc.
* Thank you for providing your responses.

1. MILDRED is a concept we use at DDEAMC to identify the special case patient referral & transport facilitation process from your MEDDAC to DDEAMC for tertiary care. (Special case may indicate that attempts were made to access by normal means with no success or the patient may be of particular command interest).

a) How would you rate your familiarity with MILDRED on the following scale? (circle):
1. Very Familiar, 2. Somewhat Familiar, 3. Neither Familiar nor Unfamiliar, 4. Somewhat Unfamiliar, 5. Very Unfamiliar.

b) Please explain briefly your response to 1.a. if you responded with a number greater than 2, explain how this could be remedied: _____

_____

_____

_____

_____

_____

_____

c) Are you satisfied with the MILDRED process established to meet the needs of your patient referrals to DDEAMC? (circle):
1. Very Satisfied, 2. Somewhat Satisfied, 3. Neither Satisfied nor Unsatisfied, 4. Somewhat Unsatisfied, 5. Very Unsatisfied.

d) Please explain briefly your response to 1.c. if you responded with a number greater than 2, explain how

this could be improved: _____

2. Who (Your MEDDAC or Equivalent) provides the Administrative coordination to obtain a referral appointment at DDEAMC? If this responsibility is decentralized to the clinics or departments please indicate below. Also indicate whether nursing or physician personnel are involved directly: _____

3. Does your staff have/or receive any written or oral guidance describing the patient referral process for the HSR? If they have written guidance please include a copy of the LOI/SOP when you return this survey. _____

4. Do you have competing/alternative sources of care that your facility selects for patient referrals instead of using the HSR (DDEAMC)? If the answer is yes, please list those sources with a major diagnosis & rationale. (For example: Yes, at MEDDAC _____ for Angioplasty we use our supplemental funds / CHAMPUS Partnerships due to patient convenience or cost effectiveness or degree of patient risk, or etc.):_____

(Please attach a your answer if more space is needed).

5. What variable impacting MILDRED (Facilitation of Patient tertiary care referral) do you percieve needs improvement? Insert a percentage value from 0 percent to 100 percent; the highest percents will indicate a greater need for improvement. You may prioritize by percentages if preferred.

__ a) DDEAMC Communication to MEDDAC about appointment

availability.
__ b) Phone system at DDEAMC.
__ c) Phone system at MEDDAC.
__ d) Clinician familiarity with process (MEDDAC).
__ e) Clinician familiarity with process (MEDCEN).
__ f) Clinician Interest with process (MEDDAC).
__ g) Clinician Interest with process (MEDCEN).
__ h) Immediacy of appointment fills.
__ i) Administrative DDEAMC POC coordination.
__ j) Patient transfer mode (MEDDAC/Ambulance).
__ k) Patient transfer mode (MEDCEN/Ambulance).
__ l) Courtesy.
__ m) Discharge Planning (Follow-up info to the MEDDAC).
n) Please list any other variables which you may want to apply a percentage value on: _____

_____

_____

_____

_____

6. Another aspect of the Health Service Regional Activity is the Consultant Visits to your MEDDAC for specialty coverage, assistance, or instruction.

a) How would you rate your satisfaction with the Consultant Visitation Program? (circle):
1. Very Satisfied, 2. Somewhat Satisfied, 3. Neither Satisfied nor Unsatisfied, 4. Somewhat Unsatisfied, 5. Very unsatisfied.

b) Please explain briefly your response to 6.a. if you responded with a number greater than 2, explain how this could be improved: _____

_____

_____

_____

_____

_____

7. Does the Consultant Visitation program add to your workload (Counted as workload generated at your MEDDAC)?

_____

8. Are the Consultant Visitations at a frequency which meets your needs? _____

_____

9. Are changes to Visitation schedules announced in a timely manner? _____

_____

10. Who coordinates Consultant Visitations to your facility? Is this decentralized to the providers in various clinics/departments? _____

_____

_____
_____
_____

11. Please provide a brief listing of how the MILDRED & the Consultant Visitation Program has improved care at your facility: _____
_____
_____
_____
_____
_____

12. What is your "Vision" of the Future for the Health Service Regionalization Activity (MILDRED & Consultant Visits) and your MEDDAC? (For example, You may perceive the role of the consultants to be more active in your Quality Assurance Programs in the future, or You may perceive a lesser role in the use of MILDRED opportunities due to the recent increase in Partnership or Managed care efforts): _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

* SURVEY COMPLETED BY: _____.
Date: _____. (PRINT and SIGN)

***** THANK YOU FOR COMPLETING THIS SURVEY *****

PLEASE SEND TO THE FOLLOWING ADDRESS:

COMMANDER
DWIGHT D. EISENHOWER ARMY MEDICAL CENTER
ATTN: CPT JAMES R. ALARCON (HSHF-DCA/CS)
FORT GORDON, GEORGIA 30705-5650

Appendix M

Service Components
of the
Health Service Regional Activity at DDEAMC
To Be Audited

This document contains questions and secondary data sources to be used in meeting the methodology phase requirements (Stages III. Through VIII.) for conducting a Marketing Audit of the Health Service Regional Activity. Contents for this document have been reviewed by the DDEAMC DCA and Deputy Commander for Regional Integration (DCRI), and structured by works from marketing authors Bond (1989), Barry (1986), Zikmund & D'Amico (1986), and Kotler (1984),

I. Marketing Environmental Audit:

MACROENVIRONMENT:

********** **(Demographic)** **********

1. What major demographic (size, age, distribution, type of beneficiary) developments or trends pose opportunities or threats to the HSR?

2. What actions has the HSR performed in response to demographic developments & trends?

3. Is the HSR doing any studies which may assist them in being aware of changes in the demographics of its user publics? e.g. Demographic changes may affect amount or types of services offered in the region.

********** **(Economic)** **********

1. What major developments, in how our publics (providers & patients) gain access to our services, may affect their use? e.g. CHAMPUS rates, Partnerships, etc.

2. What major developments are taking place that may affect how DDEAMC is reimbursed or funded for the workload generated by the HSR?

3. Have any actions been taken by DDEAMC in response to these major developments impacting the HSR?

********** **(Technological)** **********

1. What major changes in technology may affect HSR services? What is the HSR's position in these changes?

2. Are alternatives for the changes in technology available, and are they utilized?

********** (Political) **********

1. What laws are being proposed that could affect marketing strategy & tactics?

2. What federal, military, state, and local actions should be watched which may affect directly or indirectly HSR services?

********** (Cultural) **********

1. What are the provider's attitudes about the HSR & and the services that are provided? (Survey Data).

2. What changes in beneficiary & provider's lifestyles and values may impact the HSR activity?

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TASK ENVIRONMENT:

********** (Markets) **********

1. What is happening to market size, growth, and the geographical distribution of consultant services and tertiary referral (MILDRED) relative to the MEDDACs & health clinics served?

2. What are the major market segments based on secondary data available at DDEAMC for the HSR?

********** (Providers & Beneficiaries) **********

1. How do beneficiaries & providers rate the reputation and quality of services provided by the HSR? Is there a mechanism in place to capture this rating data?

2. How do the providers using the HSR decide on using its services for consultant services or tertiary care referrals?

********** (Competitors) **********

1. Who or what is considered a competitor for the HSR? What are the objectives, strategies, weaknesses, & strengths of the competition?

2. What trends may affect future competition?

********** (Distribution & Dealers) **********

1. What are the main channels for bringing HSR services to the Army regional health care facilities?

2. What are the efficiency levels & growth potential for the main channels of delivery?

********** (Suppliers) **********

1. What is the outlook for key resources used in the delivery of HSR services?

2. Are there any noticeable trends amongst the providers in their pattern of delivering HSR services?

********** (Facilitators & Marketing Services) **********

1. What is the cost & availability outlook for transportation services?

2. What is the cost & availability outlook for financial services?

3. How effective are HSR marketing services?

********** (Publics) **********

1. What public represent particular opportunities or problems for the HSR?

2. What steps has the HSR taken to deal with each public?

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****

II. Marketing Strategy Audit:

********** (Business Mission) **********

1. Is there a mission statement expressing the marketing aspect of the HSR?

2. If there is no mission statement for the HSR, why not?

********** (Marketing Objectives) **********

1. Are the DDEAMC's objectives clearly stated and do they lead logically to the HSR marketing objectives?

2. Are the HSR marketing objectives stated in a clear form to guide marketing planning and subsequent performance measurement?

3. Are the marketing objectives appropriate, given the HSR's competitive position, resources, and opportunities?

********** (Strategy) **********

1. Is there a core marketing strategy for achieving HSR marketing objectives? Is it a sound strategy?

2. Are enough resources or too much resources budgeted to accomplish the marketing objectives?

3. Are marketing resources allocated along certain segments?

4. Are marketing resources allocated based on the particular needs of the marketing mix? e.g. services, price, place, or promotion.

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****

III. Marketing Organization Audit:

********** (Formal Structure) **********

1. Does a marketing officer or equivalent have adequate authority over & responsibility for HSR activities that affect the beneficiary or provider's satisfaction?

2. Are HSR marketing activities formally distributed along functional lines (management levels) ?

********** (Functional Efficiency) **********

1. Are there good communication & working relations between those who coordinate services & those who market the HSR services?

2. Is the person or section responsible to market HSR services in need of additional training?

********** (Interface Efficiency) **********

Are there any problems between HSR marketing and the following areas: operations, nursing, finance, admissions, or purchasing?

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IV. Marketing Systems Audit:

********** (Marketing Information System) **********

1. Is the marketing intelligence system producing accurate, sufficient, and timely information about marketplace developments with respect to beneficiaries, user providers, prospects, distribution, competitors, & various publics?

2. Are HSR staff using market research when they are making decisions about services?

********** (Marketing Planning System) **********

1. Is a marketing planning system in practice at the HSR? If not, how is this task carried out?

2. Are services forecasting or volume potentials for the HSR carried out?

3. Are quotas established for services?

********** (Marketing Control System) **********

1. Are the control procedures (monthly, quarterly, etc.) adequate to ensure that the HSR annual plan objectives are being achieved?

2. Are returns (funding) to DDEAMC based on the achievement of of services rendered by the HSR periodically analyzed to determine whether certain services should be discontinued?

3. Are HSR marketing costs periodically analyzed?

********** (New Service Development System) **********

1. Is the HSR office organized to gather, generate, & screen new service ideas?

2. Does the HSR office use research methods & cost-benefits analysis before going for added services?

3. If new services are to be considered, are they tested?

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V. Marketing Productivity Audit:

********** (Profitability Analysis) **********

1. What is the profitability to DDEAMC of the different services offered by the HSR?

2. Should the HSR enter, expand, contract or withdraw from any segments, and if so, have longterm & shortterm consequences been considered?

********** (Cost Effectiveness Analysis) **********

1. Do any marketing activities seem to have excessive costs? Are these costs valid?

2. Can cost reducing steps be taken?

****
****

VI. Marketing Function Audit:

********** (Services) **********

1. What are the objectives of the services offered by the HSR? Are the objectives being met?

2. Which services should be phased out? Which services should be phased in?

3. What are the HSR services?

4. Are service descriptions available for our major services rendered?

5. Are any HSR services able to benefit from quality, feature, or style improvement?

6. What are the MEDDAC's knowledge & attitude about the services offered by the HSR and the competiton?

7. Is adequate attention being given to the identification & packaging of the HSR services offered?

********** (Price) **********

1. What are the prices or costs that the user of HSR services must incur in order to access tertiary care, and consultant services? Are objectives established which reflect how to minimize these costs incurred by the provider or beneficiary?

2. Are the prices or required prerequisite actions in balance with the value of the services?

3. Are prices based on demand, cost, or competitive criteria?

4. Does the HSR use price as a promotional variable?

********** (Place) **********

1. What are the distribution objectives & strategies?

2. Is there adequate market coverage & service?

3. Are there alternative sites or time periods to deliver services which may improve access or satisfaction?

********** (Promotion) **********

1. Are there advertising objectives for the HSR? Are they sound?

2. Is a budget established for advertising? If not, how are advertising costs computed?

3. What are the promotional activities directed toward the MEDDACs & two clinics? Do they appear effective?

4. Are advertising media well chosen? What media sources are used?

5. Is there a well conceived publicity program? If not, why?

6. What does the HSR use to persuade the MEDDAC providers to use MILDRED? How does the HSR persuade or provide incentive for DDEAMC consultant participation?

****

Source: Marketing Scholars, Bond (1989), Barry (1986), Zikmund & D'Amico (1986), and Kotler (1984).

Note: These questions follow the basic format for a service component audit. Adjustments have been made (by student)in sentence structure to facilitate the HSR audit.

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Appendix N

HSR Survey Results

Percents are based on the number of regional health care facilities (n=10)

Mildred services: (Satisfaction: Total Percent)
- Very satisfied ..... 20 percent
- Somewhat satisfied ..... 40 percent
- Neither sat nor unsat ..... 40 percent
- Somewhat unsatisfied ..... 0 percent
- Very unsatisfied ..... 0 percent

(Familiarity: Total Percent)
- Very familiar ..... 20 percent
- Somewhat familiar ..... 30 percent
- Neither fam nor unfam ..... 0 percent
- Somewhat unfamiliar ..... 10 percent
- Very unfamiliar ..... 40 percent

Consultant services: (Satisfaction: Total Percent)
- Very satisfied ..... 10 percent
- Somewhat satisfied ..... 70 percent
- Neither sat nor unsat ..... 20 percent
- Somewhat unsatisfied ..... 0 percent
- Very unsatisfied ..... 0 percent

PROBLEM AREAS

(M): Mildred services
(C): Consultant services

a. Communication to and from MEDDACs (M).
b. Clinician familiarity & interest (M).
c. Patient Transport (M).
d. Discharge planning (M) & (C).
e. Immediacy of appointment filling (M).
f. Phone systems (M).
g. Distance (M) & (C).
h. No written guidance on referral system (M).
i. Lose control of patient (C).
j. "Lack of purpose" visitors (C).
k. Inconvenient for patients (M) & (C).
l. Schedule changes (C).

POSITIVE COMMENTS

a. Increases patient access (M) & (C).
b. Increases regional communication (C).

c. Care of special problem patients (M).
d. Administrative coordination (M).
e. Patient Transport (M).
f. Cuts out the bureacracy at clinic level (M).

Visions for the HSR

a. Greater involvement in QA.
b. Lesser role due to partnerships.
c. Greater exchanges in technology.
d. Complete disillusionment with the HSR program.
e. Lesser role, using other sources of referral & consultant support.

Source: 1991 Survey of DDEAMC HSR ARMY Facilities.

Appendix O

DDEAMC HSR Marketing Symbol